Section 1:
Introduction to Health Education in Vermont

Introduction

Schools have the opportunity and responsibility to help students develop the knowledge and skills they need to be healthy and achieve academically. To achieve these goals, schools must select or develop and then implement a curriculum that is standards-based, developmentally appropriate, and respects current social needs.

The primary purpose of this manual is to support Vermont teachers in the development of curriculum, instruction, and assessment of students' knowledge and skills in health education. This guide for aligning curriculum, instruction, and assessment is based on *Vermont's Framework of Standards and Learning Opportunities,* National Health Education Standards, the work of the State Collaborative on Assessment and Student Standards, and the Centers for Disease Control and Prevention Adolescent Risk Behaviors.

What Is Included in This Manual?

The *Vermont Health Education Guidelines for Curriculum and Assessment* manual is divided into the following four sections:

Section 1: Health Education in Vermont

This section includes:

- rationale for health education
- regulations for teaching health education in Vermont
- health education within the context of a coordinated school health program
- factors considered in conceptualizing the *Vermont Health Education Guidelines for Curriculum and Assessment*

Section 2: Curriculum and Assessment Guidelines

This section includes the health education guidelines for grades pre-K through 12. The guidelines identify standards, outcomes, and assessment criteria for health education in Vermont.

Section 3: Assessment for Health Education

This section includes:

- overview of assessment
- rubric cards, which provide scoring criteria
- student posters that highlight the scoring criteria
- template for writing performance tasks
- examples of effective performance tasks
- project options

Section 4: Curriculum, Instruction, and Assessment Connections

This section includes information about effective curricula; aligning curricula, student instruction, and assessment; and a plan for designing and coordinating the development of a pre K–12 comprehensive health education curriculum.

Appendixes

The appendixes contain a variety of tools and resources to support the work of health educators in Vermont.

Rationale for Health Education

Promoting healthy behaviors to help young people acquire the knowledge and skills to become healthy and productive adults is an important part of the fundamental mission of schools. Because health-related behaviors are both learned and changeable, there is no better time to initiate formal health education than in the elementary school years, when the child is more flexible and forming health behaviors. Research has consistently confirmed and given a clear message: by promoting healthy behaviors, schools can increase students' capacity to learn, reduce absences, and improve physical fitness and mental alertness.

Public support for health education in today's schools is strong. A 1993 Gallup Survey funded by the American Cancer Society documented this high value for health education. Major findings included:

- Nearly nine in ten adolescents feel health information and skills are of equal or greater importance than other subjects in school.

- More than four in five parents of adolescents (82 percent) feel that health education is either more important than or as important as other subjects taught in school.
- Parents clearly support teaching problem solving, decision making, and other health-related skills in schools.
- Administrators view health education as being of equal to or greater importance than other things adolescents are taught in school and believe that students need to be taught more health-related information and skills in school.

Acknowledgment of the need for improved health education and behaviors comes from the corporate world as well as from the public at large. The health status of the work force is a major recognized threat to the country's economic competitiveness. Poor worker health status results in low productivity and efficiency, loss of work time, and increased costs for medical care and medical insurance to treat preventable disease. Current national efforts to improve the health of Americans urge individuals to consistently practice behaviors that promote lifelong personal health and well-being; to access quality health care services effectively; and to promote the health of others, the community, and the environment. Health knowledge and skills are as significant to economic competitiveness and education reform as the knowledge and skills taught in any other subject in the schools.

Regulations for Teaching Health Education in Vermont

In 1978, the Vermont legislature passed the Comprehensive Health Education Law (16 V.S.A. §131), which defined the ten components of comprehensive health education and established the statewide Comprehensive Health Education Advisory Council. In 1983, the Vermont Legislature passed Act 51 (16 V,S,A, § 909), mandating Alcohol and Drug Prevention Education Programs. In 1988, the Legislature amended the Comprehensive Health Education Law of 1978 to clarify the definition of Comprehensive Health Education and required health education as a course of study for grades K–12 in Vermont schools. (See Appendix A.)

In January 1999, the Vermont Department of Education published the *School Quality Standards,* which provide rules to ensure all students equal opportunities in education that would enable them to achieve or exceed expectations identified in *Vermont's Framework of Standards and Learning Opportunities.* Several sections of the *School Quality Standards* support the development of standards-based health education and assessment both at the classroom level and as part of a comprehensive assessment system. (See Appendix B.)

Health Education within the Context of a Coordinated School Health Program

A coordinated approach to school health improves students' health and their capacity to learn through the support of families, schools, and communities working together. Health education provides students the information and skills they need to make healthy choices in life. The Coordinated School Health Program (CSHP) reinforces positive healthy behaviors throughout the school community, making it clear that health education can't begin and end in the classroom. If students are to adopt healthy behaviors, they need to see the relevance to their own lives and to have the opportunity to practice healthy behaviors within their schools, homes, and communities.

For example:

- School nutrition services can serve appealing, nutritious foods that meet the Dietary Guidelines, display informational materials that reinforce classroom lessons on nutrition, and participate in the design of nutrition education programs.
- Students participating in youth programs can plan and implement schoolwide health initiatives that affect the school environment and staff/student wellness.
- Schools can offer parent education programs focusing on topics that parallel those in the classroom curricula.
- Physical education instructors can integrate instruction on health-related fitness throughout the year, including cardiovascular endurance, flexibility, muscular strength and endurance.

The following components are included in the Vermont Coordinated School Health Program Model.

Curriculum: Promoting, Learning, and Adopting Health Behaviors—The **health education** program is designed to motivate and assist students to maintain and improve their health, prevent disease, and reduce health-related risk behaviors. It allows students to develop and demonstrate increasingly sophisticated health-related knowledge, skills, and practices. In addition to separate health education courses taught by qualified, trained teachers, the Vermont Department of Education supports the integration of health instruction into physical education, driver and traffic safety education, family and consumer science, and developmental guidance, as well as other content areas.

Physical Activity: Modeling and Encouraging the Achievement of Lifelong Physical Fitness—Quality **physical education** should promote, through a variety of planned physical activities, each student's optimum physical, mental, emotional, and social development, and should provide activities and sports that students enjoy and can pursue throughout their lives. Qualified, trained teachers teach physical education. The school and community can promote the achievement and maintenance of a health-enhancing level of physical fitness through an environment that supports physical activity opportunities.

Health Services: Enhancing School Health Services—Health services include services to appraise, protect, and promote health. These services are designed to ensure access or referral to primary health care services; prevent and control communicable disease and other health problems; provide emergency care for illness or injury; and promote and provide education and counseling opportunities for promoting and maintaining individual, family, and community health. Qualified professionals such as physicians, school nurses, nurse practitioners, and other allied health personnel provide these services.

Nutrition and Food Service: Encouraging Healthful Nutrition—Nutrition services include access to a variety of nutritious and appealing meals that accommodate the health and nutritional needs of all students and reflect the U.S. Dietary Guidelines. These services are designed to include culturally and medically appropriate foods that promote growth and development, pleasure in eating, and long-term health. Nutrition education is an integral part of the school nutrition program. Qualified child nutrition professionals provide these services.

Guidance and Counseling: Supporting Social and Emotional Well-being—School counseling, psychological, and mental health services work to improve students' mental, emotional, and social health. These services include education, individual and group assessments, interventions, and referrals. Professionals such as certified school counselors, student assistance professionals, home-school coordinators, psychologists, and social workers provide these services.

School Environment: Creating Positive Learning Environments—Healthy school environment includes safe and aesthetically pleasing equipment, buildings, and grounds; a culture that promotes an equitable, safe and healthy climate for all students; and policies, procedures, and conditions that support the well-being of students and staff. To learn and teach most effectively, students and staff must be in settings where they feel safe, supported, and comfortable.

Staff and Faculty Wellness: Promoting Faculty and Staff Wellness—Faculty and staff wellness includes opportunities for fitness activities, health assessments, education, and support programs. These opportunities encourage school staff to pursue healthy lifestyles that contribute to improved health status, improved morale, and greater personal commitment to the school's coordinated health program. This personal commitment often transfers into greater commitment to the health of students and creates positive role modeling. Health promotion activities help improve productivity, decrease absenteeism, and reduce health insurance costs.

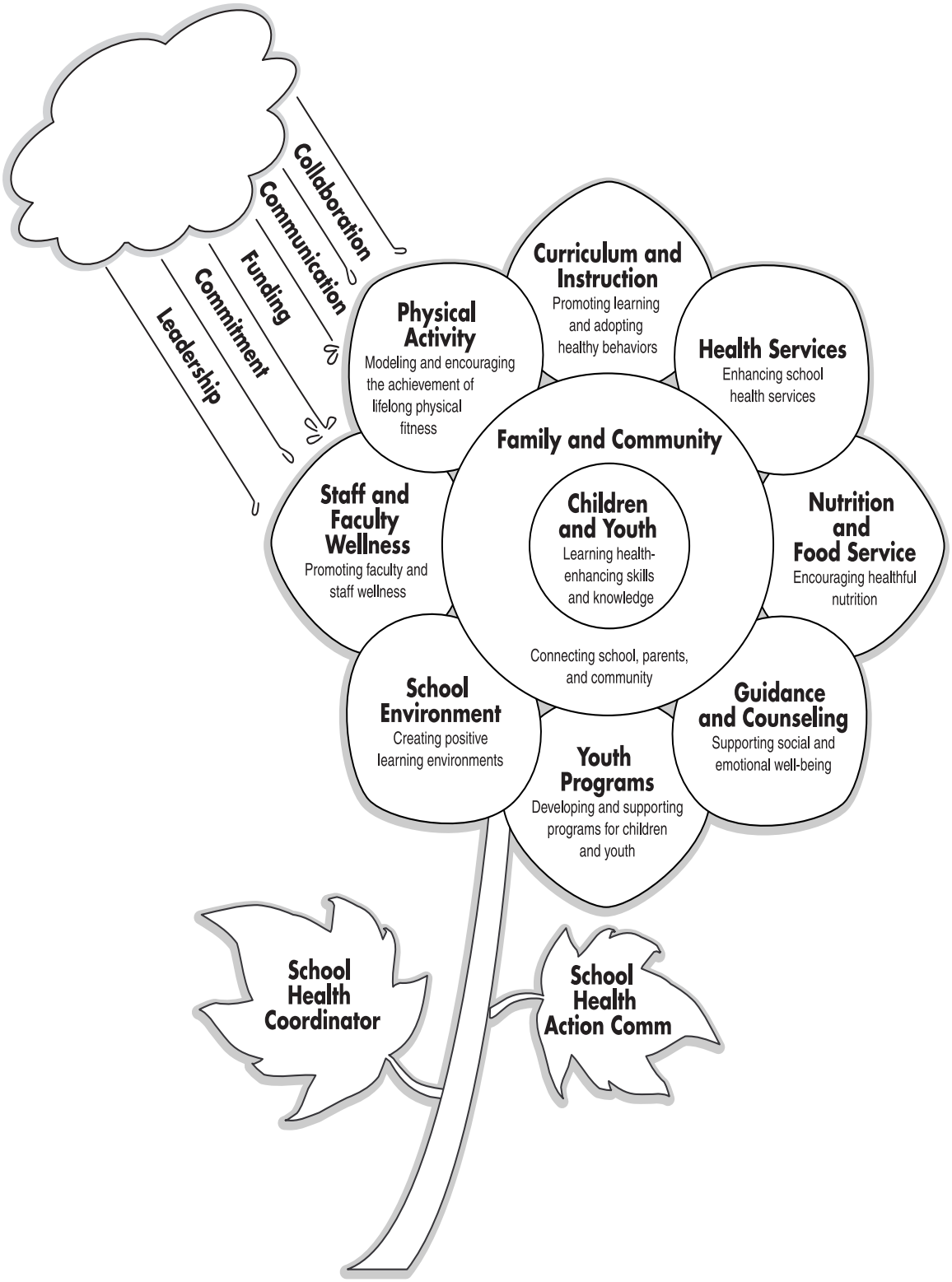
Youth Programs: Developing and Supporting Programs for Children and Youth—After-school activity programs, mentoring programs, and **youth service projects** provide children and youth the opportunity to expand their social skills, discover new areas of interest, and develop connections, as well as providing opportunities for meaningful contributions at school and in the community. These programs promote positive self-esteem, creativity, leadership, and reinforce safe, positive, healthy attitudes and behaviors.

Family and Community: Connecting School, Parents, and Community—Family and community involvement includes families, communities, and schools working in partnership to form a powerful alliance in promoting healthy and successful youth. School health coalitions can build support for school health program efforts. Schools encourage parent involvement and engage community resources and services to respond more effectively to the health-related needs of students.

School Health Coordinator and School Health Action Committee—The **school health coordinator** can play a key leadership role in linking the components and ensuring they are working together to meet student's needs. The coordinator provides the leadership for initiating collaborative actions, bringing together school leaders, faculty and staff, parents, community members and organizations, and fosters communication among these stakeholders.

The **School Health Action Committee** works with the **school health coordinator** to bolster the implementation of the components and is a vital part of the model. The role of the School Health Action Committee is to identify, prioritize, plan for, and implement action steps toward coordinating and improving school health programs. The committee membership should include representation from all of the component areas and a diverse cross-section of the community.

Vermont Coordinated School Health Program Model



Conceptualizing the *Vermont Health Education Guidelines for Curriculum and Assessment*

In developing the *Vermont Health Education Guidelines for Curriculum and Assessment,* a working group of health education professionals examined a variety of national, state, and local documents to determine the content and format of the guide. In addition, education and health research and policy were examined and used as a foundation for the development of this document. Some of the key factors that influenced the development of this manual and the guidelines include:

- *Vermont Framework of Standards and Learning Opportunities* and Vermont statutes on Comprehensive School Health
- National Health Education Standards and the link to Vermont Standards
- CCSSO~SCASS Health Education Assessment Project
- CDC Guidelines and Research-validated Curricula
- Safe and Drug-Free Schools and Communities—Principles of Effectiveness
- Risk Behaviors, Resiliency, and Developmental Assets

Vermont Framework of Standards and Learning Opportunities and Vermont Statutes

Vermont's Framework of Standards and Learning Opportunities provided one of the major driving forces in the development of these health education guidelines. *Vermont's Framework of Standards* was developed as a resource to guide schools in the development of curriculum and assessment. While health education was not identified as a Field of Knowledge, standards that focus on health literacy are an integral component of the Vital Results and Fields of Knowledge.

Vermont Law 16 V.S.A. §131 requires schools to teach comprehensive health education and lists ten components to be included: body structure and function; community health; safety; disease prevention; family and mental health; personal health; consumer health; human growth and development; alcohol, tobacco, and other drug education; and nutrition. Act 51, 16 V.S.A. Sec. 909 mandates that all students receive alcohol, tobacco, and other drug prevention education. These health education guidelines are designed to support schools in the implementation of *Vermont's Framework of Standards and Learning Opportunities* within the context of the laws that support health education.

National Health Education Standards

The National Health Education Standards provided another driving force in the development of the *Vermont Health Education Guidelines*. The National Health Education Standards, which focus on the health knowledge and skills to be assessed, are critical to the healthy development of children and youth. The implementation of the National Health Education Standards has driven the improvement of student learning across the nation by providing a foundation for curriculum, instruction, and assessment of student performance. The standards also provide a guide for enhancing teacher preparation and continuing education. The goal of the National Health Education Standards is to improve educational achievement for students and to improve health in the United States.

The Joint Committee on National Health Education Standards defines health literacy as "the capacity of individuals to obtain, interpret and understand basic health information and services and the competence to use such information and services in ways that enhance health." Health-literate people are people who:

- can think things through and make health choices in solving their own problems
- are responsible and make choices that benefit themselves and others
- are in charge of their own learning
- can use communication skills in clear and respectful ways

There are seven national Health Education Standards:

Health Education Standard 1 (Concepts–CC): Students will comprehend concepts related to health promotion and disease prevention.
This standard is linked to all content areas. Student work should demonstrate functional knowledge of the most important and enduring ideas, issues and concepts related to achieving good health.

Health Education Standard 2 (Accessing Information–AI): Students will demonstrate the ability to access valid health information and health-promoting products and services.

Health Education Standard 3 (Self Management–SM): Students will demonstrate the ability to practice health-enhancing behaviors and reduce health risks.

Health Education Standard 4 (Analyzing Internal and External Influences–INF): Students will analyze the influence of culture, media, technology and other factors on health.

Health Education Standard 5 (Interpersonal Communications–IC): Students will demonstrate the ability to use interpersonal communication skills to enhance health.

Health Education Standard 6 (Decision Making–DM): Students will demonstrate the ability to use goal-setting and decision-making skills to enhance health.

Health Education Standard 6 (Goal Setting–GS): Students will demonstrate the ability to use goal-setting and decision-making skills to enhance health.

Health Education Standard 7 (Advocacy–AV): Students will demonstrate the ability to advocate for personal, family and community health.

Linking Vermont Standards to the National Health Education Standards

Vermont's Framework of Standards and Learning Opportunities was developed in Vermont during the same timeframe that the National Health Education Standards were being developed. Yet, there is a clear relationship between the two sets of standards and thus, the assessment of those standards. The connections between the national and Vermont standards are presented in the following table.

National Health Standards	Vermont Standards and Evidence
1. Students will comprehend concepts related to health promotion and disease prevention.	**3.4** Students identify the indicators of intellectual, physical, social, and emotional health for their age and/or stage of development. **3.5** Students make informed, healthy choices that positively affect the health, safety, and well-being of themselves and others. Evidence: **a, aa, aaa** Cause & prevention of disease **b, bb, bbb** Relationship between behavior and health **g, gg, ggg** Nutrition and Food Guide Pyramid **7.14** Students demonstrate understanding of the human body—heredity, body systems, and individual development—and understand the impact of the environment on the human body.
2. Students will demonstrate the ability to access valid health information and health promoting products and services.	**3.5** Students make informed, healthy choices that positively affect the health, safety, and well-being of themselves and others. Evidence: **c, cc, ccc** Locate, access, & evaluate resources

National Health Standards	Vermont Standards and Evidence
3. Students will demonstrate the ability to practice health-enhancing behaviors and reduce health risks.	**3.3** Students demonstrate respect for themselves and others. **3.5** Students make informed, healthy choices that positively affect the health, safety, and well-being of themselves and others. Evidence: **d, dd, ddd** Recognize & manage stress **f, ff, fff** Wear seat belts & helmets **hh, hhh** Use food pyramid to guide food selection **3.12** Students use systematic and collaborative problem-solving processes, including mediation, to negotiate and resolve conflicts.
4. Students will analyze the influence of culture, media, technology, and other factors on health.	**5.14** Students interpret and evaluate a variety of types of media, including audio, graphic images, film, television, video, and on-line resources.
5. Students will demonstrate the ability to use interpersonal communication skills to enhance health.	**1.15** Students use verbal and nonverbal skills to express themselves effectively. **3.5** Students make informed, healthy choices that positively affect the health, safety, and well-being of themselves and others. Evidence: **e, ee, eee** Refusal and negotiation skills
6. Students will demonstrate the ability to use goal-setting and decision-making skills to enhance health.	**3.5** Students make informed, healthy choices that positively affect the health, safety, and well-being of themselves and others. Evidence: **b, bb, bbb** Set a personal health goal **3.7** Students make informed decisions.
7. Students will demonstrate the ability to advocate for personal, family, and community health.	**1.15** Students use verbal and nonverbal skills to express themselves effectively. **5.15** Students design and create media products that successfully communicate.

The CCSSO~SCASS Health Education Assessment Project

The CCSSO~SCASS Health Education Assessment Project (HEAP) is another driving force in the development of the health education guidelines. Vermont is a member of the State Collaborative on Assessment and Student Standards (SCASS) HEAP, which is coordinated by the Council of Chief State School Officers (CCSSO). The HEAP was started in 1993 to identify and develop assessment measures in the area of health education. The project is designed to help member states develop innovative materials to use in assessing student health performance in health education. Its major purpose is to guide improvement in health education curriculum planning and delivery. Materials developed from this project significantly influenced the development of this manual.

CDC Guidelines

CDC has published guidelines for school health programs based on a review of published research and input from academic experts and national, federal, and voluntary organizations interested in child and adolescent health. The guidelines include specific recommendations to help states, districts, and schools implement health programs and policies that have been found to be most effective in promoting healthy behaviors among youth. Recommendations cover topics such as policy development, curriculum development and selection, instructional strategies, staff training, family and community involvement, evaluation, and linkages between various components of the coordinated school health programs. CDC has published guidelines on the following four topics: tobacco use and addiction, promoting lifelong physical activity, promoting lifelong healthy eating, and prevention of the spread of HIV/AIDS.

CDC's Research-validated Curricula

In 1992, CDC/DASH began the Research to Classroom Dissemination project. The purpose of the project is to identify health education programs that have credible evidence of reducing health risks among youth. Rigorously designed evaluations of curricula with outcomes that include a reduction in health risk behavior are reviewed by a CDC panel, which considers the design of the research, the selection of the experimental and control groups, and the choice of statistical methods. A report of the evaluation findings is disseminated by CDC, and national training is available on these research-based programs.

CDC/DASH identifies criteria for tobacco use prevention curricula. Programs must demonstrate an association between exposure to the intervention and at least one of the following behavioral outcomes:

- preventing initiation of tobacco use
- reducing the prevalence of tobacco use

- increasing percentage of tobacco users quitting tobacco use
- increasing percentage of smokers reporting reduction of tobacco use

Programs for HIV, STD and unintended pregnancy must include at least one of the following behavioral outcomes in order to be considered effective.

- a delay in the initiation of sexual intercourse
- a reduction in the number of sexual partners
- a reduction in the frequency of sexual intercourse
- an increase in the use of condoms
- a decrease in pregnancy rate
- a decrease in the newly reported cases of an STD

There are advantages to adopting research-based curricula for the local schools. There is limited instructional time and that time should be devoted to programs that have been shown to work. Few local and state agencies have sufficient funding to conduct their own controlled studies of health education programs and cannot assume that well-designed local programs will necessarily produce behavioral changes. Choosing research-based curricula, which are taught with fidelity, can assure school, parent and community groups that the health education instruction provided to students has been shown to reduce risk behaviors that lead to unhealthy outcomes.

Reference: http://www.cdc.gov

Safe and Drug-Free Schools and Communities—Principles of Effectiveness

The United States Department of Education has established six "Principles of Effectiveness" to govern how recipients will develop and implement programs under Title IV—Part A: Safe and Drug-Free Schools and Communities, No Child Left Behind Act. A program or activity developed under the Safe and Drug-Free Schools and Communities Act (SDFSCA) must meet the Principles of Effectiveness and such program shall:

1. Be based on an assessment of objective data regarding the incidence of violence and illegal drug use in schools and communities, including an objective analysis of the current conditions and consequences regarding violence and illegal drug use, including delinquency and serious discipline problems, among students who attend such schools.
2. Be based on an established set of performance measures aimed at ensuring that the schools and communities to be served by the program have a safe, orderly, and drug-free learning environment.

3. Be based on scientifically based research that provides evidence that the program to be used will reduce violence and illegal drug use. (An LEA may apply to the State for a waiver of the requirement of research-based programming to allow innovative activities or programs that demonstrate substantial likelihood of success.)

4. Be based on an analysis of the data reasonably available of the prevalence of risk factors, including high or increasing rates of reported cases of child abuse and domestic violence; protective factors, assets, or other variables in schools and communities in the State identified through scientifically based research.

5. Include meaningful and ongoing consultation with and input from parents in the development of the application and administration of the program or activity.

6. Be based on the periodic evaluation of progress toward reducing violence and illegal drug use, and the results shall be used to refine, improve and strengthen the program and be made available to the public.

Reference: http://www.ed.gov/legislation/ESEA02/pg52.html

The United States Department of Education provides a list of allowable costs. The following list identifies those allowable costs that are relevant to health education curriculum.

1. **Program Requirements—**A local educational agency shall use funds made available under section 4114 to develop, implement, and evaluate comprehensive programs and activities, which are coordinated with other school and community-based services and programs, that shall:

   A. foster a safe and drug-free learning environment that supports academic achievement;

   B. be consistent with the principles of effectiveness described in subsection (a)(1);

2. **Authorized Activities—**Each local educational agency, or consortium of such agencies, that receives a subgrant under this subpart may use such funds to carry out activities that comply with the principles of effectiveness described in subsection (a), such as the following;

   A. Age-appropriate and developmentally based activities that—

      (i) address the consequences of violence and the illegal use of drugs, as appropriate;

      (ii) promote a sense of individual responsibility;

      (iii) teach students that most people do not illegally use drugs;

(vi) teach students to recognize social and peer pressure to use drugs illegally and the skills for resisting illegal drug use;

(v) teach students about the dangers of emerging drugs;

(vi) engage students in the learning process; and

(vii) incorporate activities in secondary schools that reinforce prevention activities implemented in elementary schools.

E. Drug and violence prevention activities that may include the following:

(viii) Conflict resolution programs, including peer mediation programs that educate and train peer mediators and a designated faculty supervisor, and youth anti-crime and anti-drug councils and activities.

(xiii) Age-appropriate, developmentally based violence prevention and education programs that address vicimization associated with prejudice and intolerance, and that include activities designed to help students develop a sense of individual responsibility and respect for the rights of others, and to resolve conflicts without violence.

Risk Behaviors, Resiliency, and Developmental Assets

The Centers for Disease Control and Prevention, Division of Adolescent and School Health (CDC/DASH), monitors the risk behaviors of adolescents through the Youth Risk Behavior Surveillance System (YRBS). The YRBS was designed by reviewing the leading causes of morbidity and mortality among youth and adults. In the United States, more than three-quarters of all mortality, as well as enormous morbidity, disability, and suffering, among 15- to 24-year olds results from only five causes. Motor vehicle crashes cause 31percent of all mortality in this age group; other unintentional injuries (such as falls, drownings, and poisonings) cause 9 percent; homicides cause 21 percent; suicides cause 14 percent; and HIV/AIDS causes 2 percent.

The mortality data, however, does not adequately reflect consequences of sexual behaviors established among this age group. For example, about half of all new HIV infections occur each year among those between ages 13 and 21. Further, about three million new and increasingly virulent sexually transmitted infections (STIs) occur among teenagers each year. In addition, about one million teenagers become pregnant each year. The most serious problems that afflict youth, therefore, result from only three types of behaviors: behaviors that result in unintentional and intentional injuries (such as weapon carrying), alcohol and other drug use, and sexual risk behaviors.

Similarly, about two-thirds of all deaths and an enormous amount of unnecessary morbidity and health care costs among adults age 25 and older result from just two

causes: cardiovascular disease and cancer. Three behaviors strongly associated with these causes of death are usually developed during youth: tobacco use, unhealthy dietary patterns, and inadequate physical activity.

Thus, some of the most serious problems that afflict youth and old alike result from these six types of behaviors monitored by the YRBS. These preventable behaviors are established during youth, often extend into adulthood, are interrelated, and can simultaneously cause poor health, poor education, and poor social outcomes.

The Vermont Department of Education, in collaboration with the Vermont Department of Health's Division of Alcohol and Drug Abuse Programs, has participated in the YRBS biennially since 1985. Vermont students in grades eight through twelve report health risk behaviors similar to those of youth nationally. A complete summary of Vermont 2001 YRBS data can be found at: www.state.vt.us/health/adap/pubs/2001/yrbs2001.pdf

Vermont has made a concerted effort to address the risk behaviors of youth and at the same time, initiate a complementary approach that accents healthy development of all youth by utilizing the research on resiliency and the developmental assets. The positive youth development approach is about recognizing that all youth have strengths, which we must help them develop. It is about providing our youth with caring and support, high expectations, consistent boundaries, and opportunities for meaningful participation. It is also about teaching life skills and increasing bonds between family members, between schools and students, and between students in positive ways. The Search Institute Profiles of Student Life Survey has shown that developmental assets represent a common core of building blocks crucial for all youth. Assets have been shown to have the power to protect youth against risk-taking behaviors and to promote thriving indicators. (Vermont participated in this survey in 1997–98.)

Effective health education through a coordinated school health program can help reduce risks and develop resiliency in youth. Successful health education programs are designed to equip students with the life skills they need to combat environmental factors that may place them at risk for tobacco, alcohol, and other drug use; violence; vandalism; truancy; school failure; and other unhealthy or risky behaviors. The *Vermont Health Education Guidelines for Curriculum and Assessment* reflect the concepts and skills necessary to prepare students to minimize health risk behaviors and increase their developmental assets, thus positively affecting the health and well-being of themselves and others.